Medicaid Enterprise

Iowa Department of Human Services

All Providers

II. Member Eligibility

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CHAPTER II. MEMBER ELIGIBILITY

A. DEMONSTRATION OF ELIGIBILITY

Most members will demonstrate Medicaid eligibility through a *Medical Assistance Eligibility Card.* EXCEPTIONS: It is possible that a person has or will have Medicaid coverage, but does not yet have a *Medical Assistance Eligibility Card*.

- People who have applied for Medicaid benefits may have form 470-2979*, Proof of Application for Medicaid*. This form verifies that as of the date the form is completed the person has applied for Medicaid benefits, but eligibility has not been determined. In come cases, the person may become eligible only after spending a certain amount on medical care (a "spenddown").
- Women may have a *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580, to indicate time-limited Medicaid eligibility for:
  - Covered ambulatory medical services (for pregnant women) or
  - All Medicaid-covered services (for women with breast or cervical cancer).

  These women are determined to be presumptively eligible for Medicaid pending a formal eligibility determination by the Department. Presumptive Medicaid eligibility is granted on a daily basis rather than a monthly basis.

Failure to present a current *Medical Assistance Eligibility Card* for inspection does not mean ineligibility for Medicaid. Eligibility may be verified through the Iowa Eligibility Verification System (ELVS) or the IME web portal.

Presentation of a *Medical Assistance Eligibility Card* does not guarantee that the person continues to be eligible for Medicaid or that the person is eligible for all Medicaid benefits. A person who is no longer eligible for Medicaid may present a card. See Section 4 for more information on methods of verifying eligibility.

Persons who are eligible for IowaCare coverage do not receive a *Medical Assistance Eligibility Card*. IowaCare has a separate eligibility card.

1. Medical Assistance Eligibility Card, Form 470-1911

The *Medical Assistance Eligibility Card* is issued to new Medicaid members at the time of approval. Replacement cards are issued for current members in July of each year or upon the request of the member. To view a sample of the card, click here.

Each member receives a wallet sized card plus two key chain cards. The cards display the member's name, state identification number, and birth date. The back of the card lists IME contact phone numbers for both members and providers.

Possession of the annual card does **not guarantee** Medicaid eligibility. Providers must call Eligibility Verification System (ELVS) or access the IME web portal to verify the member's specific eligibility information.

2. Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580

Possession of form 470-2580, *Presumptive Medicaid Eligibility Notice of Decision*, indicates that a qualified provider has determined that a woman is presumptively eligible for Medicaid. To view a sample of this form on line, click here.

This determination entitles a woman to time-limited Medicaid coverage as follows:

- Coverage for presumptively eligible women who have or may have breast or cervical cancer extends to all Medicaid covered services.
- Coverage for presumptively eligible pregnant women extends **only** to Medicaid-covered ambulatory prenatal care.

"Ambulatory prenatal care" means all Medicaid-covered services except inpatient hospital care and charges associated with a miscarriage or with delivery of the baby. Medicaid will pay medical expenses for ambulatory prenatal care incurred during the presumptive eligibility period even if the woman does not attain Medicaid eligibility.

A woman who is determined to be presumptively eligible for Medicaid is eligible for Medicaid services as described beginning with the date of the presumptive eligibility determination. Eligibility continues up to the last day of the month following the month of the presumptive eligibility determination.

If the woman files a Medicaid application within this period, Medicaid coverage continues until a decision is made on the application. The presumptive eligibility period ends when the Department approves or denies the Medicaid application.

3. IowaCare Medical Card, Form 470-4164

The *IowaCare Medical Card* is issued at the time of approval. The card contains the member's name, state ID number, and the code that identifies the type of IowaCare the member is covered under. The IME contact number for members is listed provided with the card. The card instructs pregnant IowaCare members where they can receive their prenatal or delivery care. To view a sample of this form on line, click here.

Having an IowaCare card does not guarantee eligibility. Providers must call Eligibility Verification System (ELVS) or access the IME secure web portal to verify the member's specific eligibility information. NOTE: Not all mental health services are covered under the fee-for-service reimbursement. Preauthorization is necessary for people enrolled in the Iowa Plan. ELVS or the web portal will indicate if the member is enrolled in the Iowa Plan.

4. Eligibility Verification

All providers of service should request and inspect the member's eligibility card on each occasion of service. The Eligibility Verification System (ELVS) and the IME secure web portal offer providers a fast, convenient method of verifying a member's Medicaid eligibility.

Either call the ELVS line or access the IME secure web portal to verify the following information.

- If Medicaid or IowaCare eligibility exists for date of service
- If the member is eligible for limited benefits such as:
  - Aliens eligible for "emergency medical services." (See Aliens Receiving Emergency Services for more information.)
  - Members eligible under the Iowa Family Planning Network who are covered for specific family planning services. (See Members Under the Iowa Family Planning Network for more information.)
  - Members eligible under the qualified Medicare beneficiary (QMB) coverage group and eligible only for the Medicare deductibles and coinsurance. (See Members Under the Qualified Medicare Beneficiary Program for more information.)

- If the member is enrolled in managed care, including a health maintenance organization, a prepaid health plan, or the Medicaid patient access to service system
- If the member is locked in to specific providers
- If the member has third party liability

Only providers enrolled in Medicaid can obtain this information. You will need to use your Medicaid provider number to access these systems.

The address of the web portal is http://ime-ediss.noridan.com/iowaxchange/. To get authorization to use the web portal, you must submit an *Additional Access Request Form for Iowa Medicaid Real-Time Transactions* to EDI Support Services. This form is available on the IME provider web page, http://www.ime.state.ia.us/Providers/.

ELVS is an automated response system that uses a touch-tone telephone to report:

- A member's eligibility status as of specific dates of service.
- Whether other third-party resources exist.
- The name of the third-party payors, if known.
- Medicaid HMO or MediPASS coverage (and telephone number).
- Services not covered by the member's managed health care plan.
- Any lock-in restrictions for the member.
- The amount of the member's Medically Needy spenddown balance for the certification period (including the date of service), if any.

The system can also give the date and amount of a provider's last payment. ELVS can process up to five inquires per call.

You should access ELVS:

- At the time service is provided or requested.
- When a woman presents a *Presumptive Medical Eligibility Notice of Decision*, form 470-2580.
- You want to find out the remaining spenddown amount to be met by a member on Medically Needy.

To use ELVS:

1. Dial either phone number with a touch-tone phone.

   Des Moines area or out-of-state: 515-725-1099
   Iowa WATTS: 1-800-323-9639

2. ELVS will greet you and ask for your choice of information. (If you do not have a touch-tone phone, please hold for further instructions.)

   - Press **1** to hear the help message.
   - Press **2** for member eligibility.
   - Press **3** for provider payment.

   When entering data, you do not need to wait for message completion. You may begin entering data after the first word is spoken for each prompt.

3. The system will ask for your provider identification number. Please enter your seven-digit ID number. If your Medicaid provider number is miskeyed or inactive, you may re-enter the number or end the call.

4. If you are an enrolled provider, ELVS will ask for a member identification number. Please enter the first seven digits of the member's Medicaid ID number, followed by the pound sign (#). (ELVS does not use the letter at the end.)

   If you do not have the member's Medicaid identification number, you may enter the member's date of birth using eight digits (month, day, and year as MMDDYYYY, e.g. 04232003) followed by the member's social security number (nine digits).

5. Enter the date of service using the eight-digit format (month, day, and year as MMDDYYYY, e.g. 04232003), or press **9** for today's date. ELVS will repeat the date and inform you whether the member is eligible for basic Medicaid services on that date. If the member has other resources available, you will be told so at this time.

6. After the eligibility information is spoken:

   - Press **1** to repeat eligibility information for this member.
   - Press **2** to enter a new member identification number.
   - Press **3** to enter a new date of service for this member.
   - Press **4** for provider payment information.
   - Press **9** to end the call.
   - Press **0** to be transferred to the IME Provider Services Unit (between the hours of 7:30 a.m. to 4:30 p.m., Monday through Friday).

Due to time lags in transferring information from the eligibility system to the claims system, updated eligibility information may not always appear on ELVS when you access the system. It takes ELVS two to three days to update.

A member with a Medically Needy spenddown obligation who does not have a *Medical Assistance Eligibility Card*, and for whom ELVS indicates ineligibility for Medicaid, may later be determined to be retroactively eligible. ELVS indicates the remaining spenddown to be met.

When the person does not have a *Medical Assistance Eligibility Card*, but you have reason to believe that the person may be eligible on a particular date of service, even though ELVS does not indicate this, contact the Department of Human Services local office for final verification. (See the *Appendix* for a list the addresses and telephone numbers of local Human Services offices.)

B. HOW MEDICAID ELIGIBILITY IS DETERMINED

Medicaid eligibility depends on such financial factors as income and property. In addition, people must meet certain other criteria, such as blindness, disability, age, or the need to support a family of dependent children.

Staff in the local Human Services offices determines eligibility for Medicaid except in the following situations:

- The district office of the Social Security Administration determines eligibility for SSI cases and for some State Supplementary Assistance cases.
- Certain providers who are authorized by the Department make presumptive Medicaid eligibility determinations for women who are pregnant or who are in need of treatment for breast of cervical cancer. For procedures, see:
  - PRESUMPTIVE ELIGIBILITY DETERMINATION FOR PREGNANT WOMEN, and
  - PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN WHO NEED TREATMENT FOR BREAST OR CERVICAL CANCER.

1. What You Can Do for a Person Who Appears Eligible

If a patient has not applied for Medicaid, is unable to pay for services, and appears to meet the requirements of eligibility as outlined under GROUPS COVERED BY MEDICAID, you may advise the patient or the patient's representative to contact the Department of Human Services local office.

Refer patients who are aged, blind, or disabled and not receiving monthly social security disability benefits or SSI to the district office of the Social Security Administration.

The *Appendix* lists the addresses and telephone numbers of local Human Services offices and Social Security offices.

2. Health Services Application, Form 470-2927 or 470-2927(S)

The basic application form for Medicaid is the Health Services Application form 470-2927 or 470-2927(S). People wishing to apply for Medicaid may obtain this form from local Department of Human Services offices, from maternal health services agencies, or from providers qualified to make presumptive eligibility determinations.

To view the English version of this form on line, click here. To view the Spanish version of this form on line, click here.

The completed form should be submitted to the local office of the Department of Human Services. See the *Appendix* for a list of the addresses of local Human Services offices.

3. Retroactive Eligibility

The local Human Services office may determine that a person is eligible for retroactive Medicaid benefits in any of the three months preceding the month in which the person applies for Medicaid, when:

- The applicant has paid or unpaid medical expenses for covered medical services which were received during the retroactive period, and
- The applicant would have been eligible for Medicaid benefits in the month services were received if an application had been filed then (regardless of whether the applicant is alive when the application is actually filed).

The applicant need not be eligible in the month of application to be eligible in any month of the retroactive period.

4. Limited Eligibility for People Who Transfer Assets

Transfers of assets for less than fair market value after August 10, 1993, disqualify a member for Medicaid payments as follows:

- For transfers by an institutionalized member or an institutionalized member's spouse, the penalty is ineligibility for Medicaid payment for:
  - Nursing facility services or an equivalent level of care in any institution.
  - Home- and community-based waiver services.
- For transfers by a noninstitutionalized member or a noninstitutionalized member's spouse, the penalty is ineligibility for Medicaid payment for:
  - Home health care services,
  - Home and community care for the functionally disabled elderly,
  - Personal care services, or
  - Other long-term care services.

Information concerning these members is on the Eligibility Verification System (ELVS) and the IME secure web portal. See Eligibility Verification.

C. GROUPS COVERED BY MEDICAID

1. Members Related to the Family Medical Assistance Programs

The Medicaid program covers:

- Recipients of the Family Medical Assistance Program (FMAP) for persons who would be eligible for the Iowa Family Investment Program as in effect on July 16, 1996 (low-income children and their parents or needy caretaker relatives).
- People terminated from FMAP because of increased earnings or increased child support.
- People under 21 who are ineligible for FMAP because they do not qualify as dependent children.
- Pregnant women and infants whose income is not more than 200% of the federal poverty level.
- Children aged 1 through 18 whose income is not more than 133% of federal poverty level.

2. Members Related to the Supplemental Security Income Program

The Medicaid program covers all beneficiaries of cash assistance under the Supplemental Security Income (SSI) program for persons who are aged, blind, or disabled, which is administered by the Social Security Administration.

The Medicaid program also covers people who are aged, blind, or disabled and would be eligible for SSI if certain conditions were met (e.g., cost of living increases not counted in Social Security benefits).

3. Members Residing in Medical Institutions

People who reside in a medical institution (a hospital, nursing facility, psychiatric institution, or intermediate care facility for the mentally retarded) for a full calendar month may be eligible for Medicaid.

These people must meet all eligibility requirements for SSI, except that their monthly income may be such that they would be ineligible to receive cash assistance through the SSI program.

There is a special Medicaid income limit in effect for persons in medical institutions. To be eligible in terms of income, the person's monthly income may not exceed 300% of the basic SSI benefit. This limit generally increases on January 1 of each year, as increases occur in the basic SSI benefit.

4. Members Receiving State Supplementary Assistance

People who receive State Supplementary Assistance are eligible for Medicaid. State Supplementary Assistance is a state program that makes a cash assistance payment to certain SSI beneficiaries and persons that are not eligible for SSI due to income slightly exceeding the SSI standard.

The monthly State Supplementary Assistance payment supplements the person's income to meet the cost of special needs, including residential care, in-home health-related care, family-life home care, a dependent person, or special needs due to blindness. Certain people eligible for both Medicare and Medicaid receive a small State Supplementary Assistance payment quarterly.

5. Children in Foster Care or Subsidized Adoptions

Children in foster care or subsidized adoptions are covered by Medicaid if the Department of Human Services is wholly or partially financially responsible for their support. Under certain circumstances, Iowa also offers Medicaid coverage to children who are placed in Iowa from other states.

6. Members Under the Medically Needy Program

The Medically Needy program provides medical coverage to people who are pregnant, under age 21, caretaker relatives, aged, blind, or disabled, and would qualify for Medicaid programs, other than IowaCare, except that:

- They have slightly too much income or resources, or
- They have substantially higher incomes but have unusually high medical expenses.

The Medically Needy income level is based on family size. People whose income is equal to or less than the Medically Needy income level are eligible for Medicaid through the Medically Needy program.

People who meet all eligibility factors for the Medically Needy program except for income are allowed to reduce their excess income through incurred medical expenses. This process is called spenddown.

Eligibility for Medically Needy members is based on a certification period. For people with a spenddown obligation, the certification period is two months. A new application is required before eligibility can be re-established.

Medical Assistance Eligibility Cards are issued for Medically Needy members:

- Who do not have a spenddown amount, or
- Who have met their spenddown obligation.

When a member has a current *Medicaid Eligibility* at the time services are received, Medicaid will pay for covered services received on that date and any subsequent services received in that month.

Medically Needy members are entitled to receive all services covered by Medicaid except:

- Care in a nursing facility,
- Care in an institution for mental disease,
- Care in an intermediate care facility for the mentally retarded.

People who have a Medically Needy spenddown obligation are "conditionally eligible" for Medicaid until they have verified enough medical expenses to meet their spenddown for that certification period. Information about the status of these people is available through the Eligibility Verification System (ELVS). See Eligibility Verification for more information.

Expenses used to meet spenddown are not payable by Medicaid. See Medically Needy Conditional Eligibility for information on how this affects billing and payment for services provided.

a. Medically Needy Conditional Eligibility

People who have a Medically Needy spenddown obligation are "conditionally eligible" for Medicaid until they have verified enough medical expenses to meet their spenddown for that certification period.

A member with a spenddown may not have a *Medical Assistance Eligibility Card* when service is requested, but may have met the spenddown, or may later be determined to be eligible retroactively.

Expenses used for spenddown are considered as a deductible and are **not** paid by Medicaid. Medicaid may cover a service provided before the member receives a *Medical Assistance Eligibility Card* if the service was not used to meet the spenddown obligation.

Expenses used to meet spenddown can include both services that would be covered by Medicaid if spenddown were met and services that would not be covered by Medicaid, such as a service provided before the Medically Needy certification period that remains unpaid at the beginning of the period.

Members who have successfully reduced their excess income through spenddown are notified what bills were used for spenddown and are, therefore, their personal obligation.

When a member has met spenddown, but eligibility has not yet been updated to reflect Medicaid coverage for the certification period, ELVS will report that the remaining spenddown is zero. The time lag between the spenddown reaching zero and the eligibility update showing the member as Medicaid-eligible should be no longer than two days.

b. Submitting Claims for a Member with a Spenddown

When you have determined through ELVS that a member has a spenddown balance to meet, submit claims for services for the conditionally eligible person or responsible relative to the IME just as if the person were eligible for Medicaid, using claim forms or electronic billing.

If the member has not met spenddown, the IME will apply the claim to the spenddown balance. Claims that are used to meet spenddown will be denied for Medicaid payment. The amount used for spenddown will be listed on the *Remittance Statement*. Claims that are not used to meet spenddown or are only partially used to meet spenddown are automatically resubmitted for Medicaid payment.

In order to apply expenses more accurately towards spenddown, you **must** bill a member's other insurance or Medicare before submitting the claim to the IME.

Claims will not be forwarded for spenddown processing if:

- They have missing or incorrect data (invalid procedure, national drug code, diagnosis, date of service, etc.).
- They post any edits for spenddown (EOB 480), insurance, or invalid data.
- The member's information is not on the Medically Needy system (EOB 270).

These claims must be corrected and resubmitted.

Conditionally eligible members who have "old bills" or other expenses that will not be Medicaid-payable need to have verification of these bills to apply them to their spenddown obligation and achieve Medicaid eligibility for current covered expenses. These claims **cannot** be filed electronically or submitted directly to the IME.

Submit claims for such services **to the member's income maintenance worker** in the DHS local office. (See the *Appendix* for a list of the addresses of local Human Services offices.) The worker will attach the necessary documentation to the claim and forward it to the IME for spenddown processing.

c. Medical Expense Deletion Request, Form 470-3931

When a prescription is filled and billed to Medicaid for a potentially eligible Medically Needy member, but the member does not pick up the prescription, the pharmacy **must** complete form 470-3931, *Medically Needy Expense Deletion Request*. To view a sample of this form on line, click here.

Fax the completed form to the IME as soon as possible to prevent claims for services not used to meet spenddown by the Medically Needy member.

7. Aliens Receiving Emergency Services

Federal immigration and naturalization laws provide limited Medicaid benefits for treatment of emergency medical conditions suffered by certain aliens.

Aliens who may be eligible for these benefits include otherwise eligible persons who do not allege status as a lawful resident of the United States or who were granted lawful status under the amnesty program. To be eligible for Medicaid benefits, such aliens must:

- Meet income and resource requirements, **and**
- Have had or currently have an emergency medical condition.

"Emergency medical condition" means a medical condition (including labor and delivery) manifesting itself by acute symptoms of such severity (including severe pain) such that the absence of immediate medical attention could reasonably result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily function;
- Serious dysfunction of any bodily part.

Any person who, in your opinion, might be eligible for Medicaid emergency benefits should be referred to the Department of Human Services office in the county in which the person claims residence. See the *Appendix* for a list of the addresses of local Human Services offices.

a. Verification of Emergency Health Care Services, Form 470-4299

Since the necessity of emergency medical treatment is a condition of eligibility under this provision, the local office of the Department of Human Services will seek verification of the emergency.

Department income maintenance workers use form 470-4299, *Verification of Emergency Health Care Services*, to obtain the date of service and to verify that an emergency service was received from the medical provider. To view a sample of this form on line, click here.

Complete the section, "**To be completed by the provider**." It is important to provide all the information requested so that the Department can determine whether an emergency service was provided. Return this form to the local Department office. Contact your local office if you have any questions regarding this form.

Following this determination and a determination that all other factors of eligibility are met, the Department will issue a *Medical Assistance Eligibility Card*, form 470-1911, to the patient.

The patient (or someone acting on the patient's behalf) must present this card to the providers of emergency service. The providers may then submit a claim for Medicaid payment in the usual manner.

b. Covered Services

Payment for treatment of an emergency medical condition is **limited** to:

- Inpatient or outpatient hospital services.
- Physician services.
- Services of an independent diagnostic laboratory or x-ray facility.

To be payable, care must be provided during the **three-day** period beginning with the date the patient presented for treatment of the emergency condition, regardless of the length of time the emergency condition exists.

If the patient presents for treatment later during that month for some **other** emergency condition, three days of treatment for that condition are also payable in that month.

If an emergency condition again takes place during a **later** month, the local office must again determine eligibility and verify the existence of an emergency condition.

8. Members Under the Qualified Medicare Beneficiary Program

The Medicare Catastrophic Coverage Act of 1988 mandated a coverage group for qualified Medicare beneficiaries (QMB). QMB coverage provides for limited Medicaid payment. Medicaid pays only for Medicare premiums (Part A or B), coinsurance, and deductibles.

To qualify for QMB, a person must:

- Be entitled to hospital insurance benefits under Part A of Medicare.
- Be within the income and resource limits specific to QMB.
- Meet all other Medicaid eligibility requirements.

Income eligibility for QMB exists if the household's income does not exceed 100% of the federal poverty level. Net countable income is determined using Supplemental Security Income (SSI) income policies.

The resource limits are twice the current SSI resource limits. Resource limits for QMB are $4,000 for an individual and $6,000 for two or more. SSI resource policies apply when determining countable resources.

A person can be concurrently eligible for QMB and Medically Needy. People who are conditionally eligible for Medically Needy and are eligible for QMB are entitled only to services covered under QMB until spenddown is met. Once spenddown is met, they are then entitled to Medicaid benefits payable under Medically Needy.

Eligibility for QMB becomes effective the first day of the month following the month of decision. Each person eligible for QMB is issued a *Medical Assistance Eligibility Card*, form 470-1911.

9. Employed People with Disabilities

Medicaid for employed people with disabilities (MEPD) is a coverage group implemented to allow people with disabilities to work and continue to have access to medical assistance. To qualify, people must:

- Be under age 65.
- Be disabled, based on SSI medical criteria.
- Have earned income from employment or self-employment.
- Have resources of less than $12,000 for an individual or $13,000 for a couple.

- Have net family income of less than 250% of the federal poverty level.
- Pay a premium assessed for each month of eligibility if gross income is over 150% of the federal poverty level.

10. Women Who Need Treatment For Breast or Cervical Cancer

Medicaid is available to women who:

- Are under the age of 65, and
- Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program, and
- Have been found to need treatment for either breast or cervical cancer (including a pre-cancerous condition), and
- Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act, and
- Are not eligible under another mandatory Medicaid coverage group.

Eligibility continues until the woman is:

- No longer receiving treatment for breast or cervical cancer;
- No longer under the age of 65; or
- Covered by creditable health coverage.

During the period of eligibility, a woman is entitled to full Medicaid coverage. Covered services are not limited to treatment of breast or cervical cancer.

11. Members Under the Iowa Family Planning Network

The Iowa Family Planning Network provides limited Medicaid coverage. It is available to women who are capable of bearing children, who are not pregnant and who:

- Were Medicaid members at the time their pregnancy ended or
- Are over age 12 and under age 45 and have countable income no greater than 200% of the federal poverty level.

Eligibility continues for 12 consecutive months beginning with:

- The month after the postpartum period ends for women who had a pregnancy end while a Medicaid member, or
- The first month in which eligibility is established for women who have income at or below 200% of the federal poverty level.

During the period of eligibility, a woman is entitled to limited Medicaid benefits. Covered services are limited to those that are either primary or secondary to family planning services. Payable services are:

Code	Description
00851	Anesthesia, tubal ligation/transection
11975	Insertion, implantable capsules
11976	Removal, implantable capsules with reinsertion
11977	Removal w/reinsert implantable contraceptive capsule
36415	Venipuncture
36416	Drawing blood capillary
57170	Diaphragm or cervical cap fitting
57410	Pelvic exam under anesthesia
58300	Insertion of intrauterine device
58301	Removal of IUD
58600	Ligation or transection of fallopian tubes abdominal or vaginal approach, unilateral or bilateral
58611	Ligation or transection of fallopian tubes when done at the time of cesarean delivery or intra-abdominal surgery
58615	Occlusion of fallopian tubes by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
58670	Laparoscopy with fulguration of oviducts (with or without transection)
58671	Laparoscopy with occlusion of oviducts (e.g., band, clip, Falope ring)
58700	Salpingectomy, complete/partial, unilateral/bilateral (separate procedure)
81000	UA by regent strips
81001	UA, auto with scope
81002	UA, routine without microscopy
81003	UA, auto without scope
81025	Urine pregnancy test
82948	Glucose, blood, stick test
84703	Gonadotropin, qualitative (pregnancy test)
85004	Automated differential WBC count
85007	Differential WBC count
85013	Hematocrit
85014	Blood count, hematocrit
85018	Blood count, hemoglobin
85025	Automated hemogram
85027	Automated hemogram
86318	Immunoassay for infectious agent regeant strip
87102	Knickers test for yeast

Code	Description
87110	Culture, chlamydia
87205	Smear, gram stain
87205	Smear, primary source, with interpretation, routine
87210	Smear, primary source, with interpretation, wt mount
87211	Smear, primary source, with interpretation, wet/dry mount
87220	Koh test
87491	Chlamydia trachomatis, amplified probe technique
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
90782	Therapeutic injection of medication (specify); subq
99000	Handling and/or conveyance of specimen for transfer from a physician's office to a lab
99001	Handling and/or conveyance of specimen for transfer from patient to other than physician's office to a lab (distance may be indicated)
99002	Handling, conveyance and/or other service in connection with the implementation of an order involving devices when devices are fabricated by an outside lab but which items have been designated, and are fitted and adjusted by the attending physician
99201	New patient office or other outpatient visit
99202	New patient office or other outpatient visit
99203	New patient office or other outpatient visit
99204	New patient office or other outpatient visit
99205	New patient office or other outpatient visit
99211	Established patient office or other outpatient visit
99212	Established patient office or other outpatient visit
99213	Established patient office or other outpatient visit
99214	Established patient office or other outpatient visit
99215	Established patient office or other outpatient visit
99241	New or established patient office or other outpatient consultations
99242	New or established patient office or other outpatient consultations
99243	New or established patient office or other outpatient consultations
99244	New or established patient office or other outpatient consultations
99245	New or established patient office or other outpatient consultations
99383	Preventive medicine service, new patient, initial, late childhood
99384	Preventive medicine service, new patient, evaluate, adolescent
99385	Preventive medicine service, new patient, 18-39 years of age
99386	Preventive medicine service, evaluate, 40-64 years
99393	Preventive medicine service, established patient, late childhood
99394	Preventive medicine service, established patient, adolescent
99395	Preventive medicine service, established patient, 18-39 years of age

Code	Description
99396	Preventive medicine service, 40-64 years of age
99420	Administration and inter health risk assessment instrument
99420	Completion of Risk Assessment form
A4261	Cervical cap
A4266	Diaphragm
A4267	Condom, nonspermicidal
A4267	Condom, spermicidal
A4268	Female condom
A4269	Spermicidal suppositories
A4269	Contraceptive foam
A4269	Contraceptive jelly
A4269	Contraceptive sponges
A4269	Vaginal contraceptive film
A4932	Basal thermometer
J1055	Depo Provera
J3490	Doxycycline
J3490	Flagyl
J3490	Vaginal cream, e.g., Terazol
J7300	Intrauterine device (IUD)
J7303	Contraceptive supply, hormone containing vaginal ring, each
S4989	Progestasert IUD
S4993	Oral contraceptive, 21-day supply
S4993	Oral contraceptive, 28-day supply
T1999	Supplies and materials provided by physician over/above normal service

12. Members Under IowaCare

The IowaCare program covers:

- Person ages 19 through 64 who are not eligible for other Medicaid coverage groups and whose countable income is not more than 200% of the federal poverty level.
- Pregnant women whose countable income is less than 300% of the federal poverty level and who can reduce their income to 200% of the federal poverty level with obligated medical expenses.
- Newborn infants of women who were receiving IowaCare at time of newborn's birth.

Applications for IowaCare may be obtained from the local Department of Human Services offices. Persons applying for IowaCare may use Comm. 239, *IowaCare Application*, or forms 470-2927 or 470-2927(S), *Health Services Application*.

An *IowaCare Medical Card* is issued to persons determined to be eligible for IowaCare benefits. The card is issued at the beginning of the 12-month certification period. IowaCare benefits may be available for one retroactive month when certain conditions are met.

IowaCare members are assessed a premium based on their income. Payment of the premium is a condition of eligibility unless a hardship exemption is requested. A member who submits a written statement indicating that payment of the monthly premium will be a financial hardship is exempted from the premium payment for that month.

The member may also use form 470-4165, *IowaCare Premium Billing Statement*, or form 470-4185, *IowaCare Premium Notice Reminder*, to request a hardship exemption. If the statement is not postmarked by the due date, the member is obligated to pay the premium.

IowaCare covers only services that are provided by a network provider. (This limitation does not apply to pregnant women.) The network providers are:

- The University of Iowa Hospitals and Clinics (all IowaCare members); or
- Broadlawns Medical Center in Des Moines (NOTE: Broadlawns Medical Center provides services only to IowaCare members who live in Polk county); or
- A state mental health institute, exclusive of the units providing substance abuse treatment, services to gero-psychiatric patients, or treatment for sexually violent predators.

Pregnant women qualifying for IowaCare who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, may receive covered services only when provided by the University of Iowa Hospitals and Clinics.

Pregnant women qualifying for IowaCare who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the covered services from any provider or general hospital that participates in Iowa Medicaid.

IowaCare services are limited to the services covered by the Iowa Medicaid program, such as:

- Inpatient and outpatient hospital care
- Physician and advanced registered nurse practitioner services
- Certain dental services
- Certain pharmacy services
- Smoking cessation

IowaCare members may receive routine preventative medical examinations from a network provider or from any physician, advanced registered nurse practitioner, or physician assistant who participates in Medicaid.

Conditions for services include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

Covered services for pregnant women who qualify for IowaCare are limited to:

- Inpatient hospital services when the diagnosis related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.
- Outpatient hospital services when the ambulatory patient group (APG) submitted for payment is 175, 304, 492, 493, or 494 and the primary or secondary diagnosis code is V22 through V24.9.
- Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.
- Inpatient hospital services when the DRG submitted for payment is between 385 and 391.7.

Services provided by a health care provider other than a hospital shall be covered as provided for other IowaCare members.

D. PRESUMPTIVE ELIGIBILITY DETERMINATION FOR PREGNANT WOMEN

The goal of the presumptive eligibility process for pregnant women is to make it easier for pregnant women to obtain medical care. Based only on a woman's statements regarding her family income, a qualified provider can "presume" that the pregnant woman will be eligible for Medicaid. Qualified providers can grant Medicaid coverage to these women to pay for the cost of ambulatory prenatal care.

Eligibility for ambulatory care coverage continues up to the last day of the month following the month of the presumptive eligibility determination. If the woman formally applies for Medicaid during this period, coverage will continue until the Department of Human Services makes a decision on the application.

NOTE: A woman who was determined to be presumptively eligible for Medicaid but who did not attain full Medicaid eligibility shall not be determined presumptively eligible again within the same pregnancy. These women must apply for and be determined eligible by the Department before Medicaid eligibility can be granted.

1. Qualified Providers

A "qualified provider" is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

- Provides one or more of the following services:
  - Outpatient hospital services
  - Rural health clinic services
  - Clinic services furnished by or under the direction of a physician, without regard to whether a physician administers the clinic itself
- Receives funds under one or more of the following:
  - Migrant Health Centers or Community Health Centers
  - Maternal and Child Health Services Block Grant Programs
  - Health Services for Urban Indians
- Participates in any of the following programs:
  - Special Supplemental Food Program for Women, Infants and Children
  - Commodity Supplemental Food Program
  - The state perinatal program

Providers must submit form 470-2579, *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations*, and be approved by the Department's Division of Financial, Health and Work Supports as qualified providers.

An approved provider that has entered into form 470-2582, *Memorandum of Understanding Between the Iowa Department of Human Services and the Qualified Provider*, can make presumptive eligibility determinations.

a. Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, Form 470-2579

A provider that seeks to be authorized to make presumptive Medicaid eligibility determinations for pregnant women shall complete form 470-2579, *Application for Authorization to Make Presumptive Medicaid Eligibility Determination.* To view a sample of this form on line, click here.

Print the form from the on-line manual or request it from the Division of Financial, Health and Work Supports. The form is self-explanatory.

Keep a photocopy for your records and send the original to the following address:

Department of Human Services
Division of Financial, Health and Work Supports
1305 E Walnut Street
Des Moines, Iowa 50319-0114

b. Memorandum of Understanding Between the Iowa Department of Human Services and the Qualified Provider, Form 470-2582

When the Department of Human Services approves the *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations*, form 470-2579, the Division of Financial, Health and Work Supports initiates form 470-2582, *Memorandum of Understanding Between the Iowa Department of Human Services and the Qualified Provider*.

To view a sample of this form on line, click here.

Form 470-2582 specifies the terms under which the qualified provider is allowed to make presumptive Medicaid eligibility determinations for pregnant women. Designees of the both the provider and the Department shall sign the form.

2. Eligibility Determination Process

Only pregnant women obtain Medicaid eligibility under presumptive eligibility provisions. The income and needs of other household members are considered in determining the pregnant woman's eligibility.

However, other household members are not entitled to receive Medicaid, unless an application has been filed with the Department of Human Services and the Department has made a determination approving eligibility.

The woman must complete the *Health Services Application*, form 470-2927 or 470-2927(S) (Spanish), and the provider completes form 470-2629, *Presumptive Medicaid Income Calculation*.

If the information provided indicates that the woman will meet Medicaid eligibility requirements, the qualified provider obtains a state identification number for her. Obtain this number from the Quality Assurance Unit of the Department of Human Services by calling 1-800-373-6306 or in Des Moines 242-6206.

The qualified provider issues form 470-2580, *Presumptive Medicaid Eligibility Notice of Decision*, to inform the woman of the decision on her application.

A woman who is determined to be presumptively eligible for Medicaid under this coverage group is eligible for Medicaid ambulatory prenatal care services beginning with the date of the presumptive eligibility determination. Eligibility continues up to the last day of the month following the month of the presumptive eligibility determination.

If the woman files a Medicaid application within this period, Medicaid coverage continues until a decision is made on the application. The presumptive eligibility period ends when the Department approves or denies the Medicaid application.

a. Completing the Health Services Application

Qualified providers shall issue the *Health Services Application*, form 470-2927, or its Spanish translation, form 470-2927(S), to a woman who requests a determination of presumptive Medicaid eligibility based on pregnancy. See Health Services Application, Forms 470-2927 and 470-2927(S), for a sample of this form.

The woman or someone acting on her behalf shall complete and sign the application. Use the information provided on the application to determine whether the woman meets the nonmedical requirements for presumptive eligibility.

Encourage the woman to apply for Medicaid by checking the "Medical Assistance" box on the application. This will allow Medicaid benefits to begin in a timely manner if the applicant meets eligibility requirements.

If the woman checked "Medical Assistance," "Facility or Waiver," or "Medicare savings program," photocopy the application. Keep the photocopy for your file. Within **two days** from the date of the presumptive determination, **send the original copy** of the application to the DHS office for the county in which the woman resides.

If the woman requested WIC (Women, Infants, and Children nutrition program) or maternal and child health services, send a photocopy to the WIC program office that serves the woman's county of residence.

b. Presumptive Medicaid Income Calculation, Form 470-2629

The qualified provider shall use the *Presumptive Medicaid Income Calculation*, form 470-2629, as a worksheet when determining the countable family income of the pregnant woman to compare to Medicaid income limits. To view a sample of this form on line, click here.

This form is updated annually when new poverty guidelines are issued. The Department will mail a sample of the new form to the qualified provider. The qualified provider is responsible for printing or photocopying a supply of the form from these samples.

Instructions for completing the form are as follows:

Section I. Parental Income

Complete Section I when the pregnant woman resides with her parents **and** she is under the age of 18 **and** is not married. If the pregnant woman is age 18 or older, is married regardless of age, or does not reside with her parents, do not complete this section. Go directly to Section II.

Line A. Enter the total gross monthly earned income of the pregnant woman's parents.

Line B. Allow a 20% work expense deduction for each parent with earned income.

Line C. Enter the amount of child care paid out when the parent incurs child care expenses due to employment. Allow only the actual amount of child care paid out, and permit only **up to** the maximum child care deduction allowed.

Line D. Subtract Lines B and C from Line A and enter the result here.

Line E. If both parents are in the home and they have earned income, add their earnings together from Line D and enter the total here.

Line F. Using the table, enter the amount of income to be diverted to meet the needs of the parents and their dependents in the home. Do not include the pregnant woman or her unborn child when determining the amount of income to divert.

Line G. Subtract Line F from Line E and enter the result here.

Line H. Enter the total monthly unearned income (social security benefits, child support, alimony, unemployment benefits, etc.).

Line I. Add Lines G and H together and enter the total here. This is the amount of parental income to consider when determining the pregnant woman's eligibility.

Section II. Income of the Pregnant Woman

Household Size. Enter the size of the pregnant woman's household. Determine household size by considering the pregnant woman, the unborn child or children, the father of the unborn child (if he is in the home), and any siblings of the unborn child residing with the pregnant woman.

Line A. Enter the total gross monthly earned income of the pregnant woman, the father of the unborn child when he is in the home, and any siblings of the unborn child. (If any siblings of the unborn child have income, create another column for their income.)

Line B. Allow a 20% work expense deduction for each person with earned income.

Line C. Enter the amount of child care paid out when the parent incurs child care expenses due to employment. Allow only the actual amount of child care paid out, and permit only **up to** the maximum child care deduction allowed.

Line D. Subtract Lines B and C from Line A and enter the result here.

Line E. Add the earnings of the pregnant woman, the unborn child's father, and the unborn child's siblings who are under age 19, if they are in the home.

Line F. Enter the total monthly child support payments paid to people outside the home.

Line G. Subtract Line F from Line E and enter the result here.

Line H. Enter the total of any monthly unearned income of the pregnant woman, the unborn child's father, and any siblings of the unborn child.

Line I. Enter the countable parental income from Line I in Section I, if any.

Line J. Add Lines G, H, and I together and enter the total countable net monthly income.

Compare the total monthly income to the income limit for the applicable household size, as indicated in the table. **Remember:** When determining household size, consider only the pregnant woman, the unborn child, the father of the unborn child, and any siblings of the unborn child who are in the home.

If the total monthly income does not exceed the income limit, the pregnant woman is presumptively eligible for Medicaid.

c. Notice of Decision

The qualified provider shall:

- Make an eligibility decision based on the information the woman provided on the *Health Services Application*, form 470-2927 or 470-2927(S), and on the *Presumptive Medicaid Income Calculation*, form 470-2629.
- Complete the *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580, to notify the woman of the presumptive eligibility decision.

See Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, for a sample of this form. To complete the form, enter the name and address of the woman and the date of the notice in the spaces provided.

If the application has been approved:

- Enter "X" for the appropriate coverage group.
- Enter the woman's state identification number.
- Enter the date the presumptive eligibility period begins. This date is usually the same date as the date on which the notice is being completed.
- Enter the date the presumptive eligibility period ends. This is the last day of the month following the month of the presumptive eligibility determination.
- Enter an "X" to indicate whether the *Health Services Application* has been submitted to the Department of Human Services. If so, indicate the local office it was sent to.

If presumptive eligibility is denied:

- Enter an "X" in the applicable box.
- Provide an explanation of the denial (such as, "You are over income"; "You have already received presumptive Medicaid eligibility during this pregnancy"; "You have creditable insurance coverage").

Enter the name, address, and telephone number of the qualified provider making the determination.

Give the white copy of the *Presumptive Eligibility Notice of Decision*, to the pregnant woman to the pregnant woman along with a copy of form 470-2629, *Presumptive Medicaid Income Calculation*.

Within five days of your determination, send the yellow copy of form 470-2580 to the Department of Human Services office in the county where the woman lives. Keep the pink copy in the pregnant woman's file.

E. PRESUMPTIVE ELIGIBILITY DETERMINATION FOR WOMEN WHO NEED TREATMENT FOR BREAST OR CERVICAL CANCER

Qualified providers can make an initial or "presumptive" determination of Medicaid eligibility for women who need treatment for breast and cervical cancer to facilitate the provision of care.

The goal of the presumptive eligibility process is to offer immediate health care coverage to women likely to be Medicaid eligible, before there has been a full Medicaid determination. Women can enroll in presumptive eligibility for a limited time before Medicaid applications are filed and processed, based on a determination of likely Medicaid eligibility from an approved provider.

A woman in this group who is determined to be presumptively eligible for Medicaid is eligible to receive all Medicaid-covered services during the presumptive eligibility period, not just services related to cancer treatment. Medicaid will pay medical expenses incurred during the presumptive eligibility period even if the woman does not attain Medicaid eligibility.

1. Qualified Providers

A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the Department of Public Health; or
- Has a cooperate agreement with the Department of Public Health to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program (BCCEDP).

Providers must submit form 470-3864, *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT)*, and be approved by the Department's Division of Financial, Health and Work Supports as qualified providers.

An approved provider who has entered into form 470-3865, *Memorandum of Understanding with a Qualified Provider for Breast or Cervical Cancer Treatment*, can make presumptive eligibility determinations.

a. Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), Form 470-3864

A provider seeking to be authorized to make presumptive Medicaid eligibility determinations for women who need treatment for breast or cervical cancer shall complete form 470-3864, *Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT)*. To view a sample of this form on line, click here.

Print the form from the on-line manual or request it from the Division of Financial, Health and Work Supports. The form is self-explanatory. Keep a photocopy for your records and send the original to the following address:

Department of Human Services
Division of Financial, Health and Work Supports
1305 E Walnut Street
Des Moines, Iowa 50319-0114

b. Memorandum of Understanding With a Qualified Provider for Breast or Cervical Cancer Treatment, Form 470-3865

When the Department of Human Services approves the *Application for Authorization to Make Presumptive Eligibility Determinations (BCCT)*, form 470-3864, the Division of Financial, Health and Work Supports initiates the form 470-3865, *Memorandum of Understanding with a Qualified Provider for Breast or Cervical Cancer Treatment*.

Form 470-3865 specifies the terms under which the qualified provider is allowed to make presumptive Medicaid eligibility determinations. The provider and the Department shall both sign the form. To view a sample of this form on line, click here.

2. Eligibility Determination Process

Only women who met the criteria of this coverage group obtain Medicaid eligibility under the presumptive eligibility provisions. Other household members are not entitled to receive Medicaid, unless an application has been filed with the Department of Human Services and the Department has made a determination approving eligibility.

The woman must complete the *Health Services Application*, form 470-2927 or 470-2927(S) (Spanish). If the information provided indicates that the woman will meet Medicaid eligibility requirements, the qualified provider obtains a state identification number for her.

The qualified provider issues form 470-2580, *Presumptive Medicaid Eligibility Notice of Decision*, to inform the woman of the decision on her application.

A woman who is determined to be presumptively eligible for Medicaid under this coverage group is eligible for Medicaid services beginning with the date of the presumptive eligibility determination. Eligibility continues up to the last day of the month following the month of the presumptive eligibility determination.

If the woman files a Medicaid application within this period, Medicaid coverage continues until a decision is made on the application. The presumptive eligibility period ends when the Department approves or denies the Medicaid application.

A new period of presumptive eligibility shall begin each time a woman is screened, diagnosed, and found to need treatment for breast or cervical cancer and files a *Health Services Application* with a qualified provider.

a. Completing the Health Services Application

Qualified providers shall issue the *Health Services Application*, form 470-2927, or its Spanish translation, form 470-2927(S), to a woman who requests a determination of presumptive Medicaid eligibility based on the need for treatment for breast of cervical cancer.

See Health Services Application, Forms 470-2927 and 470-2927(S), for a sample of this form. The woman or someone acting on her behalf shall complete and sign the application. Use the information provided on the application to determine whether the woman meets the nonmedical requirements for presumptive eligibility.

Encourage the woman to apply for Medicaid by checking the "Medical Assistance" box on the application. This will allow Medicaid benefits to begin in a timely manner if the applicant meets eligibility requirements.

If the woman checked "Medical Assistance," "Facility or Waiver," or "Medicare savings program," photocopy the application. Keep the photocopy for your file. Within **two days** from the date of the presumptive determination, **send the original copy** of the application to the DHS office for the county in which the woman resides. (See the *Appendix* for a list of the addresses of local Human Services offices.)

If the woman requested WIC (Women, Infants, and Children nutrition program) or maternal and child health services, send a photocopy to the WIC program office that serves the woman's county of residence.

b. Issuing the Notice of Decision

The qualified provider shall:

- Base the eligibility decision on the information she provided on the *Health Services Application*, form 470-2927 or 470-2927(S).
- Complete the *Presumptive Medicaid Eligibility Notice of Decision*, form 470-2580, to notify the woman of the presumptive eligibility decision. (See Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, for a sample of this form.)

To complete the form, enter the name and address of the woman and the date of the notice in the spaces provided.

If the application has been approved:

- Enter "X" for the appropriate coverage group.
- Enter the woman's state identification number.

- Enter the date the presumptive eligibility period begins. This date is usually the same date as the date on which the notice is being completed.
- Enter the date the presumptive eligibility period ends. This is the last day of the month following the month of the presumptive eligibility determination.
- Enter an "X" to indicate whether the *Health Services Application* has been submitted to the Department of Human Services. If so, indicate the local office it was sent to.

If presumptive eligibility is denied:

- Enter an "X" in the applicable box.
- Provide an explanation of the denial (such as, "You are over income" or "You have creditable insurance coverage").

Enter the name, address, and telephone number of the qualified provider making the determination in the spaces indicated.

Give the white copy to the pregnant woman. Within five days of your determination, send the yellow copy to the Department of Human Services office in the county in which the woman resides. Keep the pink copy.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-268
Employees' Manual, Title 8
Medicaid Appendix

March 23, 2007

ALL PROVIDERS MANUAL TRANSMITTAL NO. 07-1

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: ***ALL PROVIDERS MANUAL***, Chapter II, ***Member Eligibility***, Table of Contents, page 1, revised; pages 14, 16, and 21, revised; pages 20e and 20f, new; and form 470-2629, *Presumptive Medicaid Income Calculation*, revised.

Summary

The is chapter is revised to:

- Correct two statements about Medically Needy eligibility.
- Provide information about the IowaCare program.
- Update the *Presumptive Medicaid Income Calculation* with income guidelines based on the federal poverty level for 2007.

Date Effective

The presumptive income guidelines take effect on April 1, 2007. The other changes are effective upon receipt.

Material Superseded

Remove the following pages from the ***ALL PROVIDERS MANUAL***, and destroy them:

Page	Date
Chapter II	
Contents (p. 1)	July 1, 2006
14, 16	June 30, 2005
21	February 1, 2006
470-2629 (after p. 24)	4/05

Additional Information

The updated provider manual containing the revised pages can be found at:
www.ime.state.ia.us/

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-283
Employees' Manual, Title 8
Medicaid Appendix

February 22, 2008

ALL PROVIDERS MANUAL TRANSMITTAL NO. 08-1

ISSUED BY: Division of Medical Supports, Division of Financial, Health and Work Supports

SUBJECT: ***ALL PROVIDERS MANUAL***, Chapter I, ***General Program Policies***, Contents (page 1), revised; Contents (pages 2 and 3), new; pages 5, 6, and 8 through 44, revised; and the following forms:

RC-0113	*List of Emergency Diagnosis Codes*, new
470-3744	*Provider Inquiry*, revised
470-0040	*Credit/Adjustment Request*, revised

Chapter II, ***Member Eligibility***, Contents (page 1), revised; pages 1 through 21, revised; and the following forms:

470-1911	*Medical Assistance Eligibility Card*, revised
470-2580	*Presumptive Medicaid Eligibility Notice of Decision*, revised
470-4164	*IowaCare Medical Card*, new
470-2927	*Health Services Application*, revised
470-2927(S)	*Health Services Application* (Spanish), revised

Summary

Chapter I is revised to:

- Update addresses for the Revenue Collection Unit.
- Add an explanation of the Children's Mental Health Waiver and the Iowa Plan for Behavioural Health.
- Remove references to the monthly medical card as verification of Medicaid eligibility.
- Add instructions to verify Medicaid eligibility of all members through the Eligibility Verification System (ELVS) or the IME web portal for every encounter or monthly for persons receiving services on a monthly basis.
- Add information for lock-in and Medipass that was previously in Chapter II.
- Include "pay and chase" requirements for situations where a woman is pregnant, a child has insurance through the absent parent, or a child is provided preventative pediatric services with certain diagnosis codes. "Pay and chase" refers to the IME paying a provider of services despite third-party insurance coverage, then billing the insurance company for the amount that was paid.
- Include instructions for Medicare paper claims.
- Update forms used to report problems with submitted claims, which have been revised to reflect the use of the national provider identifier (NPI).

Chapter II is revised to:

- Replace information about paper Medicaid cards with an explanation of the annual issuance of plastic cards.
- Add that IowaCare members may receive routine preventative medical examinations from a network provider or any physician, advanced registered nurse practitioner or physician assistant who participates in Medicaid.
- Update forms used in determining and demonstrating eligibility.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from the ***ALL PROVIDERS MANUAL***, Chapters I and II, and destroy them:

Page	Date
Chapter I	
Contents (page 1)	July 1, 2005
5	July 1, 2005
6	February 1, 2006
8-12	July 1, 2005
13	February 1, 2006
14	July 1, 2005
15	February 1, 2006
16, 17	July 1, 2005
18	February 1, 2006
19-21	July 1, 2005
22	February 1, 2006
23-27	July 1, 2005
28	February 1, 2006
29-56	July 1, 2005
470-3744	07/05
57	February 1, 2006
470-0040	05/05
58-60	July 1, 2005
Chapter II	
Contents (page 1)	April 1, 2007
1, 2	June 30, 2005
470-2213	3/06
470-1911	3/06
470-2188	3/06
3	February 1, 2006
470-3348	3/06
4-13 *	June 30, 2005
470-2580	07/05

470-2927	03/05
470-2927(S)	05/05
14 *	April 1, 2007
15	June 30, 2005
16	April 1, 2007
17	June 30, 2005
18, 19	July 1, 2006
20	June 30, 2005
20a-20d	February 1, 2006
20e, 20f, 21	April 1, 2007

* Because of changes in the layout of the manual, the following form samples in Chapter II need to be refiled:

- Move form 470-3931, *Medically Needy Expense Deletion Request*, to follow page 12 instead of page 16.
- Move form 470-4299, *Verification of Emergency Health Care Services*, to follow page 14 instead of page 18.

Additional Information

The updated provider manual containing the revised pages can be found at:
www.ime.state.ia.us/

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise, Provider Services.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-284
Employees' Manual, Title 8
Medicaid Appendix

April 4, 2008

ALL PROVIDERS MANUAL TRANSMITTAL NO. 08-2

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: ***ALL PROVIDERS MANUAL***, Chapter II, ***Member Eligibility***, form 470-2629, *Presumptive Medicaid Income Calculation*, revised; **Appendix**, pages 1 through 11, 13, and 15 through 18, revised.

Summary

Chapter II is revised to update the *Presumptive Medicaid Income Calculation* with income guidelines based on the federal poverty level for 2008.

The Appendix is revised to update the addresses and phone numbers of Department offices, Social Security offices, and EPSDT Care Coordination Agencies.

Date Effective

The presumptive income guidelines take effect on April 1, 2008.

Appendix changes are effective immediately.

Material Superseded

Remove the following form and pages from the ***ALL PROVIDERS MANUAL***, Chapter II and the Appendix, and destroy them:

Page	Date
Chapter II	
470-2629 (after p. 24)	4/07
Appendix	
1-11, 13, 15-18	February 1, 2006

Additional Information

The updated provider manual containing the revised pages can be found at:
www.ime.state.ia.us/

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise.